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AGENTIVE THEORY AS THERAPY: AN OUTCOME STUDY

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Abstract

The present study evaluated the efficacy of a four-week seminar which emphasized the principles of Agentive Theory. This theory, compatible with theories of a phenomenological-existential perspective, was first developed by C. T. Warner. Agentive Theorists/Therapists emphasize that our negative emotions (depression, anger, etc.), are assertions or judgments we make and not feelings which happen to us, and thus call for control or expression. Forty-eight outpatients who sought help with personal/emotional problems from a department of behavioral medicine were assigned to either a Treatment or Waiting-list Control Group. Following a four-week treatment seminar, the Treatment Group made significantly greater improvement than the Waiting-list Control Group with respect to general mental health, somatization, depression, anxiety, hostility, phobic anxiety, psychoticism and anger reduction.

While Freudianism, behaviorism, and cognitive psychology have dominated the field of counseling and psychotherapy for decades, an interest has recently been renewed in the phenomenological-existential tradition in both psychological research and practice. A growing number of theoreticians and clinicians are researching the works of Kant, Descartes, Husserl, Kierkegaard, Heidegger, and Sartre in formulating theoretical and clinical applications (Packer, 1985; Faulconer & Williams, 1985; Warner, 1984; Solomon, 1983; Rychlak, 1981; Yalom, 1980; Bugental, 1981; May, 1981; May & Yalom, 1984).

Much of this resurgence has been inspired by dissatisfaction with what was first described by Edmund Husserl, and later by Jean-Paul Sartre, as *psychologism.* Williams (1983) characterized psychologism by defining the two fundamental assumptions on which it is based:

> Any system, science, or point of view is "psychologistic" if it assumes that psychological states and experiences enjoy an autonomous existence in reality, and that they in turn serve as the foundation of other experiences and human actions. A second major distinguishing feature of psychogism is a reliance on the methods and assumptions of the natural sciences in its study of human psychic experience. (p. 7)

Following the early methods established in the physical sciences, psychologists have generally concerned themselves with investigating *whether* the data are consistent with their presuppositions, as opposed to *what* the data actually offer. (Williams, 1983). Freudian psychology's emphasis on early experiences and the unconscious as the foundation of behavior, behaviorism's emphasis on a reinforcement history as motivators of action, and humanism's reification and objectification of emotions, needs, and intuitions are examples of these pre-suppositions. All of these approaches are seen by phenomenologists and existentialists to preclude the possibility of human agency because they explain by recourse to cause-and-effect relationships (Faulconer & Williams, 1985).

Many theorists/practitioners have asserted that the phenomenological-existential tradition appears to offer the only theories of human behavior based on assumptions which are non-psychologistic and thus allow for human agency (Kockelmans, 1984; Williams, 1983; Warner, 1982; Harre, 1983; Romanshyn, 1975; Van Kaam, 1966; Robertson, 1984; and Croxton, 1986). The phenomonological/existential tradition rejects both the models and methods of the natural sciences. A part of this rejection is the refusal to verify and objectify emotion, and give it the status of a casual entity (Williams, 1987).

Corey (1986) described how existentialism's theoretical orientation differs from traditionally psychologistic psychoanalysis and behaviorism.

> The existential approach developed from a reaction to two other major models, psychoanalysis and behaviorism. Existential therapy rejects their deterministic, reductionistic, and mechanistic view of human

> nature. It is grounded in the assumption that we are free, whereas the psychoanalytic view sees freedom as restricted by unconscious forces, irrational drives, and past events. (p. 73)

While some consider the existential orientation a license for undisciplined "woolly" therapists to "do their thing," Yalom (1980) concluded, "the existential approach is a valuable, effective psychotherapeutic paradigm, as rational, as coherent, and as systematic as any other" (p. 5).

Although the phenomenological-existential tradition is philosophically rich, its chief limitation, as seen by some, is its lack of empirical validation. Yalom (1980) argued that this "limitation" is not a flaw, but a necessary implication of the theoretical underpinnings of the phenomenological method itself (Liebert and Spiegler, 1982). Corey (1986) further commented:

> At this early stage in its formulation, existential psychotherapy cannot boast much rigorous research done to evaluate its claims to be an effective treatment. There are certainly some vivid and compelling case studies, but that is not systematic research. Such research is needed to determine whether existential techniques actually increase hardiness while decreasing mental and physical symptomatology. By now the position is clearly enough articulated that relevant research can take place (p. 217).

While existentialism/phenomenology has been articulated in theory, it has not often been submitted to empirical test aimed at providing validity data relevant to mental health concerns.

Consistent with a phenomenological-existential perspective, Warner (1982) recently articulated "an alternative to standard therapy" (p. 26).[1] He stated "My associates and I have developed a special kind of teaching that for many people, at least, is an alternative to [traditional] counseling and therapy" (p. 26). Warner's work has come to be known as "Self-Betrayal" or "Agentive Theory" (Warner, 1982; Johnson, 1982). In addition to his theoretical articulations, Warner (1986) organized the Arbinger Seminar where groups of people are educated in the principles of Agentive Theory.

Although Warner has offered philosophical and anecdotal support for the effectiveness of Agentive Theory and Therapy,

[1]It should be noted that Warner's approach is not avowedly phenomenological-existential. Specifically, he has placed his work in a social constructionist perspective (Warner [1986]). We believe, nonetheless, that in its essential stance regarding human nature and the ontology of emotion, it has much in common with a phenomenology. We therefore take the liberty of including it within this philosophical framework.

as yet no systematic studies have been reported which indicate the value of the perspective. Johnson (1983) stated:

> Herein lies the major problem with Warner's presentation. While his stories are inspiring and enlivening, they fail to provide scientific proof of efficacy. . . . We are unable to evaluate the present techniques. It is irresponsible and lazy of us to believe in a method which offers only testimonials. Such proof is the mark of the quack, and in medicine we would properly shy away from it. How can we accept it in psychotherapy? Warner has apparently done no follow-up to his seminars. (p. 24).

Brown, Warner, & Williams (1986) have commented on the implications such research could have:

> This approach . . . has yet to be explored in the research literature, but we suggest that it provides a crucially important direction for future investigation. Such investigation will have important implications for an understanding of "mental illness." (p. 187)

While opportunities are available to research existential/phenomenological approaches, in general, and Agentive Theory and Therapy, in particular, has not been studied with the intent of establishing its empirical validity as a means of helping people with psychological and emotional problems.

Purpose of the Study

The purpose of this study (carried out during the Spring of 1987) was to determine whether outpatients, in a Department of Behavioral Medicine, in a small western community hospital, who participated in a four-week structured seminar based on Agentive Theory, would significantly improve on selected measures of mental health.

Population and Sample

The general setting of this study was a community of approximately one-hundred fifty thousand people. The community differs from most others of comparable size with respect to religion and education. The community is comprised of individuals who are predominantly members of The Church of Jesus Christ of Latter-day Saints (L.D.S./Mormon) and houses a major university.

The population for this study consisted of adult (18 years and older) outpatients seeking therapy in a behavioral medicine facility located in Utah County, Utah. The population consisted of those subjects who reported psychological/emotional distress,

but were judged by an initial interview and scores on the *SCL-90-R*, not to be in need of crisis intervention.

The sample consisted of 43 subjects who contacted the hospital personnel office concerning assistance with problems considered psychological in nature. No specific advertising was done to attract participants. Twenty-three subjects were selected to receive the Agentive Seminar, and 20 subjects were placed on a 4-week waiting list. The assignments were made based upon the time of inquiry. If the subjects' initial inquiries were made prior to the time the Experimental Group (Group One) had been filled, they were assigned to Group One to participate in the Agentive Seminar in the order they contacted hospital personnel. The Waiting-list Control Group (Group Two) consisted of all individuals who contacted hospital personnel between the time Group One began and ended the four-week Agentive Seminar. All 43 subjects were interviewed, tested, and judged not to be a threat to themselves or others and not to be in need of crisis intervention.

Instruments

The instruments used in this study were the *Symptom Checklist-90-Revised* (*SCL-90-R*; Derogatis, 1977) and the *Anger Expression Inventory* (*AEI*; Spielberger, Johnson, Russell, Craney, Jacobs, and Worden, 1985). The *SCL-90-R* consists of a general index of mental health (Global Severity Scale) and nine sub-scales, (Somatization, Obsessive-Compulsivity, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism). Derogatis (1977) reported internal consistency scores for the *SCL-90-R* ranging from .77 for Psychoticism to .90 for Depression. Lambert, Shapiro, and Bergin (1986) recommended the *SCL-90-R* for "assessing the effects of treatment" (p. 195), recommending it as "most useful as a global index of psychopathology or psychological distress." (p. 195).

The *Anger Expression Inventory* has 24-questions divided into four sublevels: a general index of anger (Anger Expressed) and three sub-scales (Anger-Out, Anger-In, and Anger Controlled). While the *AEI* is still in the process of being standardized, Spielberger, et al. (1985) have indicated that its initial validity and reliability ratings are good.

Procedure

Forty-eight potential candidates contacted hospital personnel for services during the months of April and May, 1987. Of these

48 potential subjects, the first 23 applying for services were chosen to attend the Agentive Seminar (Group One). Two candidates, because of crisis situations, were assigned to receive "traditional" counseling. Twenty additional subjects (Group Two) were given the *SCL-90-R* and the *AEI* and then were advised they would begin the next Agentive Seminar in four weeks. Two additional potential clients did not receive either of the 2 treatment options. One moved out of state and the other's spouse suggested she not pursue treatment.

Group One participants were given four weeks of instruction (two and one-half hours each Wednesday evening) in Agentive Theory. The following concepts (Warner, 1986; Judd, 1987) were emphasized:

(1) *Conscience:* Our conscience expresses to us *our own* moral values as they apply to a given situation presently being experienced.

(2) *Self-betrayal:* When we do what goes against our own individual sense of what is right or wrong, we betray ourselves.

(3) *Self-justification:* When we betray ourselves, we justify ourselves, trying to make the wrong we're doing appear right, or at least not wrong.

(4) *Blaming:* In justifying ourselves, we regard someone else (or possibly something else) as being to blame, rather than ourselves.

(5) *Blaming emotions:* Our accusations of others are always blaming emotions.

(6) *Self-victimization:* When we have accusing emotions toward people, we believe we are their victims. We feel unjustly used by them, put-upon, wronged, disadvantaged, or threatened.

(7) *Childishness and self-righteousness:* As self-betrayers, we accuse others of doing things that make it difficult for us to do our best. If we try to do well in spite of what they are doing and "rise above it," we are acting self-righteously. We congratulate ourselves for acting "virtuously." If we use what others are doing as an excuse for ourselves, and don't try to do well, we are acting childishly.

(8) *Collusion:* When others are provoked by our blaming attitude to blame us in return, they betray themselves just as we are doing. They are certain that what's going on is all our fault—just as certain as we are that it is their fault. They feel we are provoking them to feel accusingly toward us, and we feel the same about them.

(9) *Liberation:* Since our disturbed emotions are our own doing, it is within our power to stop "doing" them, and by this means to end them.

In addition to discussing these principles, the seminar participants were asked to respond in writing to assignments given at the end of each session. These assignments were designed to assist the participants in describing how the principles being taught related to their everyday lives. While every effort was made to respond to all questions posed by the participants, these questions were usually answered in an indirect fashion. The group leader usually discussed the principle involved and offered a case study of someone in a similar situation. In this manner, the seminar participants were invited to use their agency in seeing themselves honestly in the situation as opposed to being directed to the answer by the group leader. If the question asked involved a principle to be discussed at a later time, the group leader deferred the discussion until that time.

After the four-week treatment period, the *SCL-90-R* and *AEI* were administered again to all Group One participants, as well as to Group Two subjects, who had merely completed the four-week waiting period. Group Two participated in the Seminar after the study was concluded.

Group One and Group Two were considered to be relatively comparable as they were derived from the same population, equivalent with respect to age, sex, education level, religious preference (as determined by an initial questionnaire), and nature of presenting problems (as determined by initial interview). The groups were nonequivalent with respect to the time at which they were included in the study. However, there seems to be no obvious way in which this time differential would be a confounding, mitigating variable.

Results

The complete details and results of this study are provided in Judd's (1987) unpublished dissertation available through Brigham Young University Library. A summary of results of some of the primary hypotheses are provided here.

(1) It was hypothesized that Group One would show a significant decrease (improvement) on specific measures of mental health as measured by the *SCL-90-R* and the *AEI.* Pre-and post-test mean scores were compared for each group separately by Fisher's LSD test following the 2 (group 1 vs. group 2) x 2 (pre-

test vs. post-test) split plot ANOVAS for each scale. The results of this analysis (Table 1) indicated that for Group One on the

Table 1

Pre-test and Post-test Mean Scores, Pre-test/Post-test Difference Scores, and Alpha Levels for Group One and Group Two. (Score decreases indicate improved mental health.)

	Treatment (Group One)				Waiting List (Group Two)			
	Pre	Post	Diff	p	Pre	Post	Diff	p
SCL-90-R Scales								
Global Sev.	65.04	56.65	-8.39*	.0001	65.00	60.75	-3.25*	.0158
Somatization	60.57	52.57	-8.00*	.0001	58.75	57.00	-1.75	.2807
Obsessive-Compulsivity	62.52	55.65	-6.87*	.0007	63.10	59.50	-3.60*	.0028
Interpersonal Sensitivity	63.52	57.22	-6.30*	.0014	66.55	63.75	-2.80*	.0163
Depression	66.91	59.74	-7.17*	.0001	63.65	61.00	-2.65	.1057
Anxiety	64.04	54.09	-9.95*	.0001	57.20	56.50	-0.70	.7131
Hostility	60.13	54.57	-5.56*	.0029	58.75	58.95	+0.20	.9237
Phobic Anxiety	53.22	49.00	-4.22*	.0154	52.05	52.05	0.00	1.000
Paranoid Ideation	56.48	52.13	-4.35*	.0309	62.90	58.50	-4.40*	.0099
Psychoticism	61.57	55.17	-6.40*	.0020	60.55	59.40	-1.15	.3756
AEI Scales								
Anger Exp.	19.96	16.91	-3.05*	.0160	22.10	22.60	+0.50	.6874
Anger-Out	14.57	13.47	-1.10*	.0182	14.00	14.25	+0.25	.6242
Anger-In	13.67	13.13	-0.54	.3340	15.30	15.20	-0.10	.8517
Anger-Contl.	24.30	25.70	+1.40	.0649	23.55	22.85	-0.78	.3972

*Significant Difference at the .05 level or better

SCL-90-R, a significant improvement was achieved in all 10 scores (the general index and all 9 symptoms dimensions). On the *AEI*, a significant improvement was achieved on 2 of the 4 anger dimensions. For Group Two, 4 of the total 14 scores showed a significant improvement without treatment.

(2) It was hypothesized that Group One would have significantly lower *SCL-90-R* and *AEI* mean post-test scores than Group Two. Post-test mean scores for each group were compared using Fisher's LSD test following the 2 x 2 split plot ANOVAS. The results of this analysis (Table 2) indicated that pre-test group differences were found in only 3 of the 14 sub-scales (2 on the *SCL-90-R* and 1 on the *AEI).* The Global Severity Score on the *SCL-90-R* pre-test showed no difference between the two groups. However, post-test group differences in favor of group 1 were found in 11 of the 14 total *SCL-90-R* and *AEI* subscales including the Global Severity Scale (general index of mental health).

(3) The hypothesis of primary concern was that Group One would show a significantly greater pre-/post-test decrease (improvement) than Group Two on measures of mental health. A series of one-way ANOVAS was conducted with the Reliable Change Index (RCI) scores as the dependent measures. This approach was developed by Jacobson, Follette, and Revenstorf (1984). The *RCI* is a statistic which allows for individual as well as group comparisons taking into account the reliability of the instrument/scale being utilized. The results of these analyses (Table 3) indicated that Group One subjects showed significantly greater pre-post score decreases (improvement) than Group Two in 8 of the total 14 *SCL-90-R* and *AEI* scales.

(4) In addition to group comparison statistics, the *RCI* also evaluates each subject relative to significant improvement (+), deterioration (-), or no change (0). A Test of Two Independent Proportions revealed that there was a significant difference between the proportion of subjects who improved in Group One and the proportion of subjects who improved in Group Two. Group One showed a significantly higher proportion of subjects improving on eight of the fourteen measures (Somatization, Obsessive Compulsivity, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, and Psychoticism). Table 4 provides a comparison of Group One and Group Two relative to the percentage of change for the general index of mental health and all sub-scales of the *SCL-90-R* and the *AEI.*

Table 2

Pre-test Comparisons, Post-test Comparisons,
and Pre-/Post-test Difference Scores
Between Group 1 and Group 2

(Score decreases indicate improved mental health)

	G-1 (Exp) Pre	G-2 (Wait) Pre	Diff	G-1 (Exp) Post	G-2 (Wait) Post	Diff
SCL-90-R Scales						
Global Severity	65.04	64.00	1.04	56.65	60.75	-4.10*
Somatization	60.57	58.75	1.82	52.57	57.00	-4.43*
Obsessive Comp.	62.52	62.10	-0.58	55.65	59.50	-3.85*
Interpersonal Sen.	63.52	66.52	-3.03	57.22	63.57	-6.35*
Depression	66.91	63.65	3.26	59.74	61.00	-1.26
Anxiety	64.04	57.20	6.84*	54.09	56.50	-2.41
Hostility	60.13	58.75	1.38	54.57	58.95	-4.38*
Phobic Anxiety	53.22	52.05	1.17*	49.00	52.05	-3.05*
Paranoid Ideation	56.48	62.90	-6.42*	52.13	58.50	-6.90*
Psychoticism	61.57	60.55	1.02	55.17	59.40	-4.23*
AEI Scales						
Anger Expression Inv.	19.96	22.10	-2.14	16.91	22.60	-5.69*
Anger-Out	14.57	14.00	0.57	13.47	14.25	-0.78
Anger-In	13.67	15.30	-1.63*	13.13	15.20	-2.07*
Anger-Control	24.30	23.55	0.75	25.70	22.85	+2.85*

*Significant Difference at the .05 level or better

Table 3

Pre- to Post-test Reliable Change Index Change Difference Scores, Alpha Levels, Standard Deviations, and and Standard Error (S_E) Scores For Group 1 vs. Group 2 Comparison

(Larger change scores show greater pre-post decreases or greater improvement in mental health.)

	RCI Change Scores					
	G-1	G-2	Diff	p	S.D.	S_E
SCL-90-R Scales						
Global Severity	-3.70	-1.43	2.27*	.0250	9.34	2.27
Somatization	-1.63	-0.36	1.27*	.0100	11.85	4.91
Obsessive Comp.	-1.39	-0.73	0.65	.1300	8.04	4.93
Interpersonal Sens.	-1.19	-0.53	0.66	.0820	8.48	5.31
Depression	-1.89	-0.70	1.19*	.0430	9.11	3.78
Anxiety	-1.66	-0.12	1.78*	.0020	12.15	5.99
Hostility	-0.95	+0.03	0.098*	.0340	9.17	5.85
Phobic Anxiety	-0.68	0.00	0.68*	.0510	9.74	6.21
Paranoid Ideation	-0.56	-0.57	0.01	.9811	11.21	7.78
Psychoticism	-0.78	-0.14	0.64*	.0080	11.42	8.16
AEI Scales						
Anger Expression Inv.	-0.33	+0.50	0.83	.1040	9.60	9.16
Anger-Out	-0.21	-0.10	0.11	.5540	3.63	2.69
Anger-Control	+0.59	-0.29	0.88	.0588	5.00	2.37

*Significant Difference at the .05 level or better

Table 4

Percentages of Group 1 and Group 2 Subjects Making Positive, Negative and No Change Relative to Reliable Change Index (RCI) Scores

Scale	(n = 23) % Group 1			(n = 20) % Group 2		
	+	0	–	+	0	–
SCL-90-R Scales						
Global Sev.	57	43	00	50	40	10
Somatization	39*	61	00	15	80	05
Obsessive Comp.	26	74	00	10	90	00
Interpersonal Sensitivity	39*	61	00	10	90	00
Depression	39*	61	00	10	85	05
Anxiety	39*	61	00	15	75	10
Hostility	30*	70	00	05	80	15
Phobic Anxiety	26	70	04	10	85	05
Paranoid Idea.	17	83	00	10	90	00
Psychoticism	09	91	00	00	100	00
AEI Scales						
Anger Expression	00	100	00	00	100	00
Anger-Out	04	96	00	00	100	00
Anger-In	04	96	00	00	100	00
Anger-Control	17	83	00	10	80	10

*Significant Difference at the .05 level or better

Discussion

Participants in the four-week seminar in Agentive Therapy generally made progress in the resolution of their personal/emotional problems. Group One (Experimental Group) subjects showed considerable decrease in symptoms on 12 of 14 measures of mental health. When compared with Group Two (Waiting List Control Group), Group One showed greater improvement than Group Two on 12 of 14 measures with 8 significant at the .05 level. When considering individual rather than group improvement, the Reliable Change Index showed that 57% of Group One subjects improved significantly on the Global Severity Scale—a general measure of mental health. This result may be considered comparable to the 66 percent reported as an average client improvement rate (Lambert, et al. 1986). This percentage of improvement seems more impressive considering the relatively short period of direct therapeutic (or educational) contact accomplished in a group setting (2 1/2 hours per week for 4 weeks). Eysenck (1952) asserted that two-thirds of people with "neuroses" improve over time whether they receive therapy or not. In this current study, while Group Two showed improvement on only 4 of 14 measures, an analysis of individual change showed an impressive 50% of these on the waiting list changed positively on the Global Index of Mental Health. One could reason that when people seek professional help, they are at or near the "high point" of their problem (Garfield, 1986). Possibly whether the client receives therapy or not, problem severity may decrease with the anticipation that help will soon be received. This explanation may account for the finding of some improvement of individuals' mental health in both groups and confirm the ability of humankind to work through problems.

Another possible influence on spontaneous remission could be the influence of the unique cultural setting (primarily members of the L.D.S. Church) in which this study took place, as religious affiliation and religious participation have both been reported to be facilitative of mental health (Judd, 1987). Another positive cultural influence may be the large and intimate "social network" provided by immediate and extended families (Brehm and Smith, 1986).

While this study was not designed to focus on specific problems, participants in the Agentive Seminar showed significantly greater decrease than non-participants on the following scales, listed in order of greatest to least change. Depression, Anxiety,

Somatization, Phobic Anxiety, Hostility, Psychoticism, Anger Expression (global anger), and Anger-Out. Group Two did not show a significant decrease (spontaneous remission) on any of these scales, but did show a significant decrease on the Obsessive-compulsivity, Interpersonal Sensitivity, and Paranoid Ideation scales. These data may support Lambert's (1986) assertion that while some problems are solved without professional help, other problems may not be resolved without it.

While the limitations of this study precluded an in-patient sample, significant improvement for Agentive Seminar subjects was achieved on measures of Psychoticism and Phobic Anxiety, which is somewhat descriptive of an in-patient population. Forty-eight percent of the seminar participants showed significant improvement on the Psychoticism sub-scale, and 44 percent showed significant improvement on the Phobic Anxiety sub-scale. These data for Seminar participants compare with 15 percent of non-participant subjects showing significant improvement on the Psychoticism sub-scale, and 5 percent of non-participants showing improvement on the Phobic anxiety sub-scale. Although research with a more disturbed population is needed, this study shows that the Agentive Seminar assisted people in decreasing their psychotic and phobic kinds of thoughts, feelings, and behavior. This finding supports the assertion by Brown, Warner, and Williams (1986) that Agentive Theory "will have important implications for an understanding [and treatment] of 'mental illness'" (p. 187).

One area in which hypothesized results were not forthcoming was the Anger dimension. Seminar participants showed significantly greater improvement than non-participants in the general measure of Anger (Expression) and the Anger-Out scale, but there were no significant differences on Anger-In (anger held in) and Anger-Control (anger diffused) scales. These results were unexpected because the Agentive Seminar focuses to a great extent on negative emotions such as anger. The Anger Expression Inventory is a new instrument, and validity is still being determined. The Hostility scale of the *SCL-90-R* did show Seminar participants to be significantly less hostile than Group Two as measured with the Reliable Change Index.

Since Agentive Therapy was shown to be an effective means of symptom reduction for Agentive Seminar participants, perhaps a discussion of the possible reasons for the success is appropriate. While most therapies focus on clinical results, the efficacy of any therapy must be based on its philosophical foundation (Harre, Clarke, De Carlo, 1985). One of the basic assumptions of Agentive

Theory is that people are responsible not only for their thoughts and actions, but also their feelings (positive and negative). Individuals are responsible not merely for managing such feelings, but for the very creation of them. The Agentive Seminar participants were invited to see themselves, others, and the world in general from a radically different perspective. Instead of perceiving their negative thoughts and feelings as responses to their internal and external environments, the participants were assisted in understanding that their negative thoughts and feelings are assertions or judgments they were making in both tacit and explicit ways. The participants were then taught that if these negative thoughts and feelings are something *they are doing*, as opposed to something *they are caused to do*, the possibility exists that they can stop doing them. Many Seminar participants expressed their perception that Agentive Theory is a "hopeful" perspective as they are free and responsible to act for themselves, and their thoughts, feelings, and behavior are not determined solely by external circumstances. While Agentive Theory stresses individual responsibility for the creation of negative feelings, these negative feelings are part of one's cultural experience—growing up believing that no other alternative exists than to "respond" to given situations with negative emotion. The notion that emotions are assertions rather than cause and effect responses is growing in support (Tavris, 1982; and Solomon, 1983).

Another possible contributing factor to the apparent success of the Agentive Seminar is represented by the fact that 16 of the 23 participants in the Agentive Seminar attended with their spouses. Husbands and wives participated jointly in the seminar, then had easy access to each other for discussing and reviewing the material together. Four of the Seminar participants (husbands) mentioned during the exit interview that their wives had asked them to go with them to see a "marriage counselor," but they had declined at that time. However, they all consented to attend the Agentive Seminar because it seemed less invasive of their privacy.

The Agentive Seminar appears to provide a means to reach a large number of people and assist them in an efficient and effective way to ameliorate their to personal/emotional problems.

Recommendations for Future Research

As with most research projects, this investigation, with its limitations, has provided insight into some questions, but has raised many more.

(1) Inasmuch as this study has addressed the question, "Does it work?" further studies may seek to answer the question, "What is the relative effectiveness of Agentive Therapy as an invitation to change when compared with other theories/therapies?"

(2) Instrumentation needs to be developed which would access experiences of guilt, blame, anger victimization, styles of self-betrayal (self-righteousness, childishness, perfectionism, martyrism), collusion, liberation, and the sense of social responsibility—all of which are central to the understanding of mental health as well as mental illness.

(3) This study dealt with an out-patient population, further research could be done in an in-patient setting. Such research would provide an opportunity to assess the efficacy of Agentive Theory for a more severely disturbed clinical population.

(4) While this study was designed to assess efficacy with respect to a diverse population, one of the most dramatic outcomes was the assistance the seminar appeared to provide for married couples. Employing measures such as marital satisfaction, and cohesiveness, may provide important insight into marital interaction.

(5) Further studies can be designed to reduce such possible confounding variables as the Hawthorne effect. In addition, the experimenter/counselor variable could be controlled better by comparing different sections of the Seminar taught by different leaders.

Implications for Practice

(1) As the principles taught in the Agentive Seminar appear to be in harmony with many of the teachings of Jesus Christ, this particular articulation may provide a means by which counselors and/or clients may be involved in the counseling process without compromising their religious values. Members of the LDS Church particularly may resonate to the basic concepts of Agentive Theory, thus reducing resistance to change. Research comparing LDS/non-LDS participant improvement may also be beneficial.

(2) Inasmuch as the Agentive Seminar is educational in principle and practice, it may be perceived as less threatening than some other more traditional form of individual or marital therapy, particularly for those with invasiveness concerns.

(3) The Agentive Seminar is short-term (four-weeks, twelve hours), thus reducing the financial burden and time constraints of the client and the time constraints of the counselor/therapist.

(4) The Agentive Seminar is not designed to address the specific problems of specific participants. The participants are invited to make personal application of the general concepts being presented. This manner of presentation provides the participant an opportunity to take responsibility for his/her own problems and solutions.

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